MEDRX

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DATE OF REVIEW: 7/14/15

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
The item in dispute is the prospective medical necessity of Left Knee Cortisone injection with Depo Medrol and xylocaine.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

☒Upheld (Agree)

☐Overturned (Disagree)

☐Partially Overturned (Agree in part/Disagree in part)

The reviewer agrees with the previous adverse determination regarding Left Knee Cortisone injection with Depo Medrol and xylocaine.

PATIENT CLINICAL HISTORY [SUMMARY]:

is a male with left knee pain reportedly due to a work-related injury on xx/xx/xx. He has had attempts with NSAIDs, home exercises and restricted duty without benefit. He uses hydrocodone for pain relief. According to report, has prior Supartz injections, four in total, from 2/4/2010 through 3/4/2010. There was a subsequent series of 5 Supartz injections from 11/23/2010 through 12/20/2010. He has had prior steroid injections on 3/5/2014, 5/25/2014, 7/9/2014, 8/3/2014, 11/14/2014, and 1/8/2015 that did offer improvement. His exam reveals restricted mobility with loss of extremes of extension and flexion with crepitus. An effusion is present. There is joint line tenderness and ligament stability is noted. McMurray test is

negative. X-rays show severe joint space narrowing and arthropathy. The diagnosis is traumatic arthropathy.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

ODG, in its "Knee" chapter, allows for intra-articular steroid injections for short term use only with at least 5 of the following: documented knee pain, bony tenderness, crepitus on active motion, ESR less than 40 mm/hr, less than 30 minutes of morning stiffness, no palpable warmth of the synovium, over age 50, rheumatoid factor less than 1:40, and normal synovial signs. Additionally, the number of injections should be limited to three.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**

☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**

ODG, “KNEE” CHAPTER

Criteria for Intraarticular glucocorticosteroid injections:

· Documented symptomatic severe osteoarthritis of the knee according to American College of Rheumatology (ACR) criteria, which requires knee pain and at least 5 of the following:
(1) Bony enlargement;
(2) Bony tenderness;
(3) Crepitus (noisy, grating sound) on active motion;
(4) Erythrocyte sedimentation rate (ESR) less than 40 mm/hr;
(5) Less than 30 minutes of morning stiffness;
(6) No palpable warmth of synovium;
(7) Over 50 years of age;
(8) Rheumatoid factor less than 1:40 titer (agglutination method);
(9) Synovial fluid signs (clear fluid of normal viscosity and WBC less than 2000/mm3);
· Not controlled adequately by recommended conservative treatments (exercise, NSAIDs or acetaminophen);
· Pain interferes with functional activities (e.g., ambulation, prolonged standing) and not attributed to other forms of joint disease;
· Intended for short-term control of symptoms to resume conservative medical management or delay TKA;
· Generally performed without fluoroscopic or ultrasound guidance;
· Absence of synovitis, presence of effusion preferred (not required);
· Aspiration of effusions preferred (not required);
· Only one injection should be scheduled to start, rather than a series of three;
· A second injection is not recommended if the first has resulted in complete resolution of symptoms, or if there has been no response;
· With several weeks of temporary, partial resolution of symptoms, and then worsening pain and function, a repeat steroid injection may be an option;
· The number of injections should be limited to three.